12-011.08A Rate Period: The rate period for each facility covers services provided January 1 through December 31 of each year. A Rate Period may be identified as either a Rebase Year or an Interim Year –

12-011.08A1 Rebase Year: A Rebase Year occurs January 1, 2001, and every third year thereafter, i.e., January 1, 2004, January 1, 2007, etc.

12-011.08A2 Interim Year: An Interim Year is every year that is not a Rebase Year.

12-011.08B Report Period: Each facility shall file a cost report each year for the twelve-month reporting period of July 1 through June 30.

12-011.08C Care Classifications: A portion of each individual facility's rate may be based on the location and the waivered/non-waivered status of the facility. The care classifications are -

1. All Nursing Facilities in urban areas;
2. Nursing Facilities in urban areas which are non-waivered;
3. Nursing Facilities in urban areas which are waivered;
4. All Nursing Facilities in non-urban areas;
5. Nursing Facilities in non-urban areas which are non-waivered; and
6. Nursing Facilities in non-urban areas which are waivered.

12-011.08D Prospective Rates for a Rebase Year: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department determines facility-specific prospective per idem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the immediately preceding June 30th Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums are computed after initial desk audit, and are not revised based on subsequent desk audits or field audits. Only cost reports with a full year's data are used in the computation. Cost reports from providers entering or leaving the NMAP during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of five components:

1. The Direct Nursing Component;
2. The Direct Support Services Component;
3. The Other Support Services Component;
4. The Fixed Cost Component; and
5. The Inflation Factor.

The facility's prospective rates are computed as the sum of these components, subject to the rate limitations of this system. The Direct Nursing, Direct Support Services, Other Support Services, and Fixed Cost components are expressed in per diem amounts. The Inflation Factor is a percentage computation.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the allowable costs for nursing salaries (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Each facility's base per diem is arrayed with all other facilities in the same care classification (see 471 NAC 12-011.08C), to include Classifications 2, 3, 5, and 6; the median base per diem is determined; and a maximum base per diem is computed at 125% of the median base per diem. If the maximum base per diem for waivered facilities in their respective urban or non-urban care classification is greater than the maximum base per diem for non-waivered facilities in that same care classification, the Department shall use the maximum base per diem for non-waivered facilities. Rate determination for the Direct Nursing Component for an individual facility is computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.08D2 Direct Support Services Component: This component of the prospective rate is computed by dividing the combined allowable costs of: the Nursing Cost Center which are not included in 471 NAC 12-011.08D1 (lines 104 through 127 from the FA-66); raw food from the Dietary Cost Center (line 53 from the FA-66); plant utilities (lines 139 through 141 from the FA-66) and cable television service (line 143 from the FA-66) from the Plant Related Cost Center; the Activities and Social Services Cost Center (lines 164 through 183 from the FA-66); Resident Transportation - Medical from the Ancillary Cost Center (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (line 203 through 210 from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Each facility's base per diem is arrayed with all other facilities in the same care classification, to include classifications 1 and 4; the median per diem is determined; and a maximum per diem is computed at 115% of the median per diem. Rate determination for the Direct Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.08D3 Other Support Services Component: This component of the prospective rate is computed by dividing the combined allowable costs of: the Administration Cost Center; the Dietary Cost Center, excluding raw food which is included in Direct Support Services; the Housekeeping and Laundry Cost Centers; and the Plant Related Cost Center, excluding utilities and cable television service, which are included in Direct Support Services, by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Each facility's base per diem is arrayed with all other facilities in the same care classification, to include classifications 1 and 4; the median per diem is determined; and a maximum per diem is computed at 115% of the median per diem. Rate determination for the Other Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.08D4 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Rate determination for the Fixed Cost Component for an individual facility is computed using its own per diem as computed above.

12-011.08D5 Inflation Factor: This component of the prospective rate is computed each Report Period from cost reports required to be submitted:

12-011.08D5a: From all reporting facilities, facilities included in the computation are those that: 1) did not have more than a 3% increase or decrease in occupancy from the previous Report Period, and 2) maintained an occupancy level at 85% or greater (see 471 NAC 12-011.06B Total Inpatient Days).

12-011.08D5b: Desk audited cost reports for the current and the previous Report Period for the remaining facilities are used.

12-011.08D5c: Each facility's average cost per day for each period is computed, adjusted for increases/decreases in case-mix acuity, and then compared to this computation from the previous Report Period. Percentage changes are arrayed from low to high.

12-011.08D5d: The Inflation Factor is the median percentage change, multiplied by 1.5 to adjust the Factor forward from the midpoint of the Reporting Period to the midpoint of the Rate Period. The Inflation Factor may not be less than "0%".

12-011.08E Prospective Rates for an Interim Year: The Interim Year rate determination utilizes each facility's prior Rate Period rates, increased by the Inflation Factor as computed per 471 NAC 12-011.08D5d, except that the median is not increased by the 1.5 adjustment factor.

12-011.08F Exception Process: For Interim Years only, an individual facility may request, on an exception basis, the Director of HHS Finance and Support to consider specific facility circumstance(s), which warrant an exception to the computed Inflation Factor. An exception may only be requested if the facility's adjusted cost per day increase as computed in 471 NAC 12-011.08D5c is 2 percentage points or more than the median increase. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total cost increase to be 2 percentage points or more above the median increase, with justification for the reasonableness and necessity of the increase;
2. whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operation; and
3. Preventive management action that was implemented to control past and future cause(s) of identified cost increase(s).

12-011.08G Rate Payment for Levels of Care 35 and 36: Rates as determined for Levels of Care 35 and 36 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08F may be adjusted for actual payment. The payment rate for Levels of Care 35 and 36 shall be the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

12-011.08H Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

12-011.08J Initial Rates for New Providers: Providers entering the NMAP as a result of a change of ownership shall receive the rate of the seller for the Direct Nursing, Direct Support Services, Other Support Services, and Inflation Factor Components. The Fixed Cost Component shall be controlled by provisions of 471 NAC 12-011.06E Leased Facilities, 471 NAC 12-011.06G Interest Expense, 471 NAC 12-011.06H Recognition of Fixed Cost Basis, and 471 NAC 12-011.09 Depreciation.

Providers entering the NMAP for a reason other than a change of ownership shall receive, rates determined from the average base rate components of all providers of the same Care Classification, plus the adjusted Inflation Factor, at the time of entering. Provider shall comply with provisions of 471 NAC 12-011.10, Reporting Requirements and Record Retention.

12-011.08K Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 471 NAC 12-011.10, Reporting Requirement and Record Retention.

12-011.08L Provisions for Governmental Facilities - City and County Owned Nursing Facility Proportionate Share Pool: A proportionate share pool is created to increase reimbursement to city and county owned facilities. City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility. The pool is created subject to availability of funds and subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

The proportionate share pool is calculated by comparison of the Nebraska Medicaid care classification of residents (see 471 NAC 12-013 Classification of Residents and Corresponding weights) to Medicare's RUG III care classifications. Each facility's Medicare rates, adjusted by the wage index published in the Federal Register are compared to equivalent Medicaid rates by resident. When more than one Medicare classification could be applicable to a Medicaid classification, an arithmetic average of the Medicare rates is computed.

The methodology shall adjust for pharmacy, laboratory, radiology, retroactive payment adjustments, and any other factors necessary to equate Medicaid to Medicare payment methodologies.

The Department shall annually submit to HCFA workpapers demonstrating the calculation of the proportionate share pool, and that calculations have not resulted in payments in excess of the amount which could reasonably be paid under Medicare payment principles.

The pool for each Report Period is calculated and distributed on or about October 1 of that Report Period. Each facility's distribution amount is based on its estimated proportionate share of the pool.

The initial proportionate share pool is created beginning January 1, 1998. Because this is the midpoint of the July 1, 1997 through June 30, 1998, Reporting Period, the pool is prorated to one half. The date for the estimated distribution for this initial prorated period will be on or about April 1, 1998.

City and County owned facilities may retain as a participation fee, the greater of:

1. $10,000; or
2. For facilities with a 40% or more Medicaid mix of inpatient days, the current NMAP Federal Financial Participation percentage multiplied by the facility's allowable costs above the respective maximum for the Direct Nursing and the Direct Support Services Components. Maximums for non-rebase years are those computed using the rebase year computation plus the inflation factor(s) for the following year(s).

12-011.08M Facility Closures: For services provided on or after July 1, 1994, when a facility closes under the following circumstances:

1. Event(s) have precipitated the movement of all residents from the facility within a period of time not to exceed 45 days (the closeout period); and
2. The facility is not certified to provide NF services for a minimum of 30 days after the final resident leaves; and
3. Cost inefficiencies result in the facility costs being over their current prospective rates, then payment is made as follows:
   a. Reasonable and necessary costs which are incurred during the closeout period (the time period from the date of movement of the first resident through the final resident) will be allowed. "Unusual" costs (for example, excessive use of pool labor because permanent employees have left) must be submitted to the Department for approval;
   b. A final cost report for the period of July 1 through the end of the closeout period must be filed in accordance with 471 NAC 12-011.10. Schedules detailing the actual "unusual" costs incurred per a. above, and the actual daily census for the closeout period must also be submitted. Two final rates shall be computed:
      (1) For the closeout period - the identified "unusual" closeout cost and the prorated portion of total period costs shall constitute the total closeout period costs. Actual inpatient days for the closeout period are used to compute the per diem. Rates are not subject to the Direct Nursing, Direct Support Services, or Other Support Services maximums. The Administration expense limitation in 471 NAC 12-011.06N is waived, along with occupancy limitations in 471 NAC 12-011.06B;
      (2) For the period prior to the closeout period - the rate shall be computed from the remainder costs/census in accordance with rates computed through provisions of 471 NAC 12-011.08D through 12-011.08D4;
      (3) The Department shall retroactively adjust interim rates paid to the allowable rates computed per (1) and (2) above.

12-011.09 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

At the time of an asset acquisition, the nursing facility shall use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 1998 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility shall have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 12-011.06H and J.

12-011.09A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

12-011.09B Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be -

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;
3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 12-011.06H and J);
4. Based on the fair market value at the time of donation in case of donated assets. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

12-011.09C Purchase of an Existing Facility: Unless there is a comprehensive appraisal by a Member of the Appraisal Institute (MAI), the Department uses the following guidelines to determine a reasonable allocation of the allowable basis to furniture and equipment for which "component" depreciation may be claimed.

Variable for Classification	Basic Cost Bases Under 40 Beds	Variable for For 40 to 75 Beds	Over 75 Beds
Moveable furniture	$1,000 per bed	$1,000 per bed	$1,000 per bed
Dietary equipment	2 1/2% decrease to "Basic" for each bed	$25,000	1% increase to "Basic" for each bed
Laundry equipment	"	$20,000	"
Heating equipment	"	$10,000	"
Air Cond. equipment	"	$10,000	"

12-011.09D Recapture of Depreciation: Depreciation in 471 NAC 12-011.08D refers to real property only. A nursing facility which converts all nursing facility beds to assisted living beds is not subject to recapture provisions. A long term care facility which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times \text{Sales Price - Book Value}$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

Examples:		Data
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4-2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

12-011.09E Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

12-011.09F Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

12-011.10 Reporting Requirements and Record Retention: Providers shall submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation shall prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct/reduce/eliminate data. Providers are notified of changes.

Each facility shall complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 15 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department shall suspend payment. At the time the suspension is imposed, the Department shall send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider shall maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a cost report has not been filed, the sum of the following is due:

1. All prospective rate payments made during the rate period to which the cost report applies;
2. All prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets shall be retained for a minimum of five years after the assets are no longer in use by the provider. The Department shall retain all cost reports for at least five years after receipt from the provider.

Facilities which provide any services other than certified nursing facility services shall report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any Medicare certified facility shall not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

12-011.10A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Social Services Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the nursing facility name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Central Office; pick up copies at the Department's Central Office; or mail copies). The total fee, $5.00 handling for each report requested and an additional $5.00 for each report to be copied and an additional $2.50 for each report to be mailed, must accompany the request. The nursing facility will receive a copy of a request to inspect its cost report.

12-011.11 Audits: The Department shall perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Prospective rates and care classification maximums are determined after the initial desk audit is completed. Subsequent desk and field audits will not result in a revision of care classification maximums.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider shall deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department but must be sufficiently comprehensive to ascertain that the cost report complies with the provisions of this section. The provider shall deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit -

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 12-011.15 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 12-011.15 #2 or when grounds exist to suspect that fraud or abuse has occurred.

12-011.12 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department shall determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on an MC-7, "Explanation of Medical Claims Activity." Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. (See 471 NAC 12-011.16 for an exception to the 45-day repayment period.) Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion.

The Department shall determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department shall immediately begin recovery from future facility payments until the amount due is fully recovered.

The Department shall report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

12-011.13 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of $25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than $25,000, or both.

12-011.14 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Department within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

12-011.14A Reconsideration Process: In place of or in advance of requesting an administrative appeal, a facility may request a rate payment reconsideration with the Department or its designee for a specific Level of Care 35 or 36 resident. The facility must submit information on the client's need for professional medical care, supervision or other needs that justify a rate payment at Level 51 or 52. Note: The reconsideration process neither limits nor promotes the facility's responsibility to make MDS changes on a quarterly basis or whenever a "significant" change has occurred, as federally defined (see 471 NAC 12-007 through 12-007.06).

To request reconsideration, the NF must submit information on the resident's needs, with supportive documentation, to the Department or its designee. Such supportive documentation shall include the degree of instability involved and the frequency of intervention in one or more of the following areas of the MDS:

1. Section B.5. Indicators of delirium, periodic disordered thinking awareness, for residents with the diagnosis of mental illness, mental retardation or a related condition (developmental disability), dementia, or a brain injury. The behavior must be present and not of recent onset (Code 1).
2. Section E.1. Indicators of depression, anxiety, and/or sad mood. The behavior must be exhibited (Code 1 or 2) PLUS an indicator in Section I of a disease of psychiatric/mood.
3. Section J. Health Conditions (present in the last 7 days unless other time frame is indicated) that affect the stability of condition and/or require professional nurse monitoring.
4. Section O. Medications that require professional nurse administration and/or monitoring.
5. Section P. Special Treatments and Procedures #2 for Section E indicators and Section I disease of psych/mood.

Other documentation supporting the need for nursing judgement or intervention may also be submitted.

The following conditions shall not constitute valid reasons for reconsideration:

1. Lack of informal support;
2. Amount of time the person has resided at the nursing facility, with payment either through Medicaid or through another source;
3. Presence of a specific diagnosis without supporting documentation of the need for nursing judgement or intervention; and
4. Advanced age.

12-011.15 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

12-011.16 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days prior to any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under this section has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.